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ABSTRACT

The nature of professional sociological roles and the problems faced by the clinical sociologist are addressed. Professional sociologists are those whose primary occupational identity is that of counselor, consultant, or administrator working in a non-academic setting. Clinical sociology is defined as counseling or other actions for intervention to alter, influence, and change social process and/or structures at any level of social organization. These levels include the individual and intimate group; the organization, agency, corporation or other bureaucratic organization; and the community or entire society. Most clinical sociologists seek to restore people to control or power over these processes and structures. Two problems face the practicing sociologist: the extent of the practioner's power over the client and the irony of selling services on the marketplace. The clinician can check abuse of his/her power over the client through minimal intervention and through providing the client with means for continued self-management. The second problem forces the practitioner to confront the ethical dilemma of how one can sell services and continue to help the client. The conclusion is that the freedoms of private practice outweigh the disadvantages and compensate for the difficulties in establishment. (Author/KC)

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THE SOCIOLOGIST IN PRIVATE PRACTICE

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Who looks up a sociologist in the Yellow Pages and phones us for an appointment? Nobody. There is no such listing and no public or professional recognition of what a sociologist can do for them. Yet, if our discipline is to survive the next few decades in viable fashion, we must develop "professional" roles for our graduates outside the academic workplace. While there has been some development of applied sociological roles within agencies and similar settings, private practice remains virtually unexplored.

However, we have found that a large but unknown number of sociologists have for some time been out there not only contemplating but doing something they call "clinical sociology." There is a session on the subject at the current A.S.A. meetings. Many of these individuals, as well as an unknown number of sociological consultants are already doing private practice (see Glass, 1979). In this paper, I should like to discuss the nature of professional sociological roles (following the distinction made in psychology), and then to consider two of the major dilemmas confronting any sociological practitioner but especially those who engage in private practice: the irony of professional power and the irony of selling one's services on the marketplace. [1]

The Problem of Identity.

We must retain our sociological perspective. "Sociological practice," "applied" and "clinical" sociology all refer to what I term professional sociology. For example, however we define them, "clinical" and "consulting" are but forms of professional sociological roles, which form part of a more inclusive set we might denote as "general sociology" or "the discipline of sociology," which is but one possible way of defining a field within the "social and behavioral sciences," which term refers to one way of slicing up "the sciences," and so

forth. There are no ontologically real boundaries here, merely conventions.

If we ignore the artifactual, arbitrary, historical and contingent nature of these distinctions we will make fools of ourselves. Borrowing from contemporary physics, in the time honored tradition of the social and biological discipline, let us note that in this universe there exist continua and processes-- not pigeonholes. When I speak, for example, of "clinical sociology" I am referring to an abstraction, generalization and codification of a range of professional roles occupied by actual people ~~and~~ which we can agree are properly subsumed under that rubric. If we look at process and function-- implied by the dramaturgical metaphor of "role"-- we can undercut most of the problems incurred by the question, "What is it, really?"

Rather, it is appropriate to consider the range of roles a person might enact which are consistent with the idea "he/she is acting as a sociologist." I state this carefully since one individual might simultaneously enact any number or combination or hybrid roles, or might at various times and places enact roles that are outside our conception of a sociologist-- such as political activist, parent or life insurance salesman. However, we can speak of six ideal-typical roles which a sociologist might perform in doing sociology:

Counsellor
Consultant
Activist
Administrator
Researcher
Educator.

This typography contrasts the ideal-typical role of the "purely" clinical, professional sociologist (counsellor) with that of "educator." In effect, those roles which are most compatible with one another are listed in closest proximity to one another. Generally, for instance, the last two most clearly fit our expectations for a Ph.D. sociologist working within the university.

Obviously it is more complex than that. There are at least two major considerations regarding professional role. One is the nature of the workplace or context of action: academic or non-academic. This seems to be enormously important in our self-definitions. More subtly, we see that any of these six sociological roles can take primacy for the individual sociologist, alone or in some combination with one or two others. We can speak of "sociology" as one's disciplinary identity but within that one's primary specification of that identity as "researcher" or "counsellor" or "educator" as one's occupational identity. Most of the confusion around clinical and applied sociology revolves around the implicit notion that there is something mutually exclusive and economically significant about occupational identity, and that the nature of one's workplace makes a critical difference with this regard.

In reality, occupational identity and workplace are only ecologically-linked and our strong distinctions are spurious. Let us consider the typical sociological role of university faculty member. This essentially involves an academic workplace. Within that workplace, the faculty person is expected to combine the primary roles of educator and researcher; generally there is some degree of both role conflict for the occupant and of conflict between the workplace's definition of the situation and his/her own. At the university level, the sociologist typically considers his/her real work to be research and teaching a necessary evil-- the administration generally considers these of equal importance or, in less prestigious and undergraduate-centered institutions, considers the teaching more important. Administrative duties of various sorts fall upon the faculty member, such as membership in committees.

However, we can define the counsellor role as including "all talking cures, semantic excercises... treatment through clarification of subjective experiences and meanings" (Hàlmos, 1966:3). This may take the minimal form of giving advice,

as when counselling a student with regard to graduation. This is expected of faculty members. However, as Jan Fritz discusses (1979) the classroom itself can be turned into a counselling experience in the strict sense, above. Similarly, educators often take on outside consulting jobs. More and more are abandoning the traditional value-neutrality and redefining their educator's role to incorporate Marxist, feminist or other activism. Glassner and Freedman characterize the activist "as a person whose treatment of social situations is based upon advocacy of specific political or moral beliefs" (1979: 13). In other words, while the faculty member identifies primarily as educator and/or researcher, he or she may also enact any or all of the other ideal-typical sociologist roles.

We are left with the dichotomy regarding workplace. There is no sense in drawing a role distinction between academic and non-academic sociology per se, but it is true that some sociologists work primarily in or primarily outside of the university setting. Most typically, those whose primary occupational identity is that of counsellor, consultant or administrator work in non-academic settings along with applied researchers. While any individual may freely move between settings and roles, or work part-time in each, for the most part those who serve in these capacities may be characterized as <u>professional</u> sociologists; until recently there has been no need nor interest in selecting an adjective to describe those who work in the university, primarily in educator-cum-researcher roles with varying degrees of administrative responsibility. It is rather insulting to term them <u>academic</u> sociologists, although that is our best description for the workplace and its contingencies. Obviously, these are exceedingly loose characterizations and describe merely the sociologist's primary occupational identity in ideal-typical terms.

Within our typification of professional sociological roles there is, obviously,

enormous range. I would make the general distinction between clinical and consulting practice-- yet, Gouldner has pointed out (1965) that there can be a clinical, as opposed to engineering approach to consultation. These are, once again, ideal types and only analytically polar antimonies. In the broadest terms, I would subsume most roles described as "applied sociology" within that of consultant, which can be loosely defined as giving advice, making recommendations or performing services for, to enhance the functioning of or in some other way to serve the needs of institutions, organizations and other social structures. This can be almost indistinguishable, at the extreme end of its spectrum, from the services of other applied behavioral scientists, management, marketing, personnel or other business consultants, engineers and experts.

When we turn to clinical practice, we need to make it clear that professional sociologists can treat as their client entities at any or all levels of social organization. Sociologists universally view individual human beings as inseparable from their social contexts, but the symbolic interaction tradition even goes so far as the view the "individual" as actually a social system in its own right, rather than as a metaphysical or psychological entity. Thus, the sociologist may treat individuals either or both as social entities and as group members. At the other end of the scale, the sociologist may seek to treat communities, social worlds and entire societies. For the sake of clarity, we might wish to differentiate three scales of social organization: the individual and intimate group; the organization, agency, corporation or other bureaucratic institution; and the community or entire society. Clinical practice at the "micro" end of the spectrum may be almost indistinguishable from roles taken by psychologists, social workers or other counselling professionals; at the middle-level, it may be very similar to consultation; at the most macroscopic level, it may blend into political activism. The scale of client is not central to any understanding of

what clinical sociology is all about.

Rather, in instrumental terms we might define clinical sociology as primarily involving counselling or other action for intervention to alter, influence and change ongoing social processes and/or social structures at any level of social organization. Often the clinician also adopts secondary roles as educator, researcher, consultant and/or administrator. In fact, these already institutionalized roles may be exploited as the means for bringing about desired change. Thus for Lee (1979) clinical work at the middle level involves primarily making recommendations for change and only indirectly involves overt action as change agent. Glassner and Freedman (1979) discuss how the macro-clinician might work through agencies and community institutions to bring about social change. In all cases, the specifically clinical element involves taking the role of change agent rather than service provider.

While it is probably not necessarily linked to the instrumental function, clinical sociology seems to invariably imply a humanistic value orientation. Thus most clinical sociologists organize their counselling or other action for intervention to restore people, individually and collectively, to control or power over social processes and/or social structures. At the "micro" and middle levels of the organizational spectrum, this generally involves bringing about those changes necessary that the human individuals affected by our interventions can break out of the "victim" role and gain self-determinism and power over their individual and collective potentialities. At the macroscopic extreme, this may become indistinguishable from revolutionary activism. Lee (1979) considers Thomas Jefferson in this light. Even more clearly, we can certainly credit Mao Tse Tung with the dramatic reorganization of Chinese society based upon his social and economic theories. While it would be absurd to include revolution within a reasonable definition of clinical sociology, the role of revolutionary

represents a limit toward which macro-clinical sociology strives asymptotically.

In general, private practice seems most suitable for clinical sociologists working at the micro to middle levels of social organization and for other forms of sociological consultation at the middle-level of corporations, agencies, community groups, hospitals and other organizations. In all these cases, we are presented with two prominent and critical ironies.

The Irony of Power.

When I speak of the Chinese revolution as clinical sociology, I do so with a point in mind. Revolutionary movements share a decidedly authoritarian or even totalitarian approach to the induction and management of social and personal change. There lies the great irony of all intervention, whether at the level of individual social actors or of entire societies: some sort of power differential seems to invariably be involved in changing any established order at any level of social organization. Somebody takes the role of controller, usurps some degree of power and control and from this clearly superordinate status initiates the actions of intervention. I do not know of a single case of change where this has not been true.

The irony lies in the idea that, to accomplish human liberation, one must create a dictatorship of the proletariat, or to teach self-control one must first control the client. The client is our client because that person or group is unable to change its situation or relationship to its situation by itself given its available resources and has come to define the situation as intolerable (or, more cynically, can be gotten to define the situation as intolerable). Otherwise our help would neither be needed or wanted. As clinicians, we are called upon to step into the situation, to intervene applying our professional skills to break the deadlocked situation and create change. Alternatively, as consultants,

we must convince the appropriate powers in the commercial or institutional world that we can provide expert services which can do something for them they themselves cannot do and which cannot be gotten from other suppliers.

Unfortunately, history shows that the state never quite seems to wither away. Few counsellors actually terminate the helping relationship or do not impose their own values and realities upon their client. The rhetoric is always that we are doing this, temporarily of course, for your own good. We must strive to realize this rhetoric in our practice since we cannot avoid the power differential itself. The clinician's stated purpose is to help individuals and groups achieve effective control over social processes and institutions-- yet we find ourselves constrained to accomplish this by imposing interventions upon the client from the superior status of professional helper or expert. We cannot hide from the dilemmas of such a relationship but, rather, must strive to ensure that we are not defining nor getting the client to define as "their" interests what are, in fact, our own and not theirs at all. We must strive to intelligently use and not abuse our structural power-- or else we should get out of professional practice.

Based upon my own experience as a sociological practitioner, I would like to offer some principles which can serve in this regard. First, our goal should be the <u>minimal intervention</u> feasible for that particular case. We should minimize both the time span of the helping relationship and the extent to which we interfere with or seek to change the client's realities, lifestyle, definitions of the situation, values or social organizational patterns. Second, our goal should in all cases be to provide that client, whether an individual or group, with means for continued self-management. The closer the clinical or consultant role approximates that of educator rather than "doctor," of trainer and coach rather than mechanic or tinkerer, the more likely we are to avoid the abuse of our power over the client. If we work to provide those minimal inter-

ventions necessary to make self-management possible so that the client can accomplish whatever it is they determine to be desireable and proper, and then to adequately train the client in actual strategies for self-management, then we have done the job correctly as I see it.

Our goal should be to get in, do what we must, teach the client how to take over from us and get on with their show. Constructing such self-limiting relationships, similar to those favored by behavioral counsellors, may not provide either the ego gratification, professional power nor "professional" incomes for us that might be achieved through more conventional tactics. However, this represents in my opinion the best and perhaps only way to translate our ideals into the realities of practice.

The Ironies of Selling our Services on the Marketplace.

Being in practice boils down to having clients which, in our socioeconomic system, means we must sell our services on the marketplace. This is true for all "professions" whatever their self-image or public facade (see Roth, 1974), and it is even more clearly true for the private practitioner who has no more indirect way of obtaining clients. This leads to both structural and ethical dilemmas.

Structurally, the terms "clinical sociologist" or "sociologist" itself convey nothing to most people as Berger has noted (1963). There are no recognized niches in the ecology of the marketplace bearing those titles; there are no such listings in the Yellow Pages or in people's minds. Thus the practitioner is forced to continually define his/her role for the public or the specific prospect and so create a niche. Otherwise one must "pass" as something already institutionalized-- hypnotist, counsellor, business consultant, etc. The lack of institutionalization and recognized "need" for our services enormously complicates the problems of private practice.

There are two primary routes of entrance into private practice in our society. One is the "professional route" which involves extensive academic training and often interneship, then having the novice practitioner affiliate with a group practice or institution such as a hospital or clinic, and then proceed to build up a professional reputation and following. This route encourages the development of professional referral networks, which provide one's primary means of attracting new clients. Without intake, there can be no practice; a viable practice depends upon a sufficient flow of new clients. This route is slow, often torturous, but it is most consistent with one's professional image, identity and purposes. Furthermore, it offers the prospect of a stable practice on the long term. However, it is almost impossible to take this route when one represents a new, unrecognized professional group-- although, by starting off on a part-time basis, one can eventually develop a full-time practice following this route.

On the other hand, there is also a "commercial" alternative in which the novice (with or without "professional" training) goes directly into the marketplace and offers his/her services. This may involve placing ads in the phone directory or carrying or mailing a prospectus to potential clients. Classically it involves hard-sell advertising campaigns on the television, radio and in newspapers and other printed media. This promises much quicker start-up and can generate a very large clientiele in minimal time-- but it also defines what one is doing as "a business" and directly conflicts with implicit norms governing "professional" decorum and practice. Furthermore, this is a capital-intensive strategy that requires an increasing investment of resources in advertising to keep going. However, some areas such as weight and smoking control are already highly commercialized as competitive markets; the same thing is beginning to happen in stress consultation for businesses and agencies.

Under such conditions, the entrant with limited capital is at an enormous disadvantage. Similarly, many of us have chosen social science careers because we are not attracted to entrepeneurial or bureaucratic careers and their contingencies. Thus we are at a disadvantage in the face of competitors who are able and willing to treat their practices as "a business" and to promote and manage their practices as commercial enterprises. I find that I entered into practice through this route, unwittingly, and have for some three years been struggling to convert it into the professional route form. Granted, I initially experienced a literal flood of clients and income, but this quickly petered out and I have found myself both unable and unwilling to enter into no-holds-barred competition. Even if I wanted to do so, I could not afford the expense of television advertising campaigns-- and such costs would ultimately mean that clients would have to pay more for my services. The commercial model also implies that one charges as much as one can get away with without diminishing profitability.

Thus the commercial route forces one to very early one confront the ethical dilemma of private practice: how can one sell help and yet continue to really help the client? Since any practitioner is, ultimately, in business for themselves, these problems are not limited to any particular mode of private practice. But if one explicitly organizes and runs one's practice as "a business" then it becomes even more clear that one's professional interests may begin to take precedence over the interests of the client. One must have an adequate flow of clients and one must get enough money from one's clients to both pay the costs of operation (including advertising) and provide one's living (whether or not one wishes to emulate the upper-middle-class lifestyle of entrenched professional groups). There seems to be an inevitable contradiction between these economic needs and looking out for the client's interests.

The consultant cannot prosper who alienates his/her employers by making "unacceptable" recommendations-- whether or not they are called for by the actual facts of the matter. Similarly, it is in the clinician's interest to establish long-term helping relationships (ala psychoanalysis) and to minimize his/her investment of time, money, attention or energy with regard to any one particular case or one's overall caseload, while maximizing profitability. In both cases of the consultant and the counsellor, it is in their interest to get people to define a need for their services. Often we create new needs and new problems or dysfunctions. For example, with the explosion of a literature on female sexuality in the popular press, sexuality counsellors have begun to see an increasing number of women who report, as their complaint, the fact that they are not multiorgasmic or have (heaven forbid!) vaginal orgasms. The data on what some females can experience has become normative and failure to live up to these new norms for sexuality can lead to the same sort of distresses produced by the normative force of the older, pre-scientific notions of sexuality.

The irony is that in a market economy we must sell our help as something to be bought and sold and promoted just like any other commodity or service. We are forced to have "good business sense," regardless of its consequences for our clients. Furthermore, to the degree we establish new social and economic roles for ourselves as professional sociologists, we are creating new social and economic needs in the societal marketplace and/or are getting people to redefine existing problems or needs as requiring our services rather than those of others. We are thus in competition with other service providers and even with one another-- and our own ideals.

This state of affairs makes cooptation into an entrepeurial frame of mind very, very easy. If we avoid that pitfall, then we are tempted to fall into

a frame of mind in which we so take our activity for granted that we consider our role to be all-important and that clients exist in order for us to carry out this role. I would term this performance arrogance (in contrast with performance anxiety). I have seen this even in the free clinic situation where there is no profit to be made but only status to be gained and reinforced: the clients can wait, we can treat them as objects, they are here for us and we are not here for them. This leads to an attenuation of the all-important client-helper bond, development of an overtly or covertly superior attitude on the helper's part, and an increasing focus of attention upon the performance of our role-- our impersonations and actions-rather than upon the client and doing something for the client. This seems inextricably tied to the social, economic and cultural contingencies of professional activity-- but especially in the private practice setting.

There is no sure resolution to this problem. Developing a group practice situation can help in many ways, such as providing opportunities for peer review or "self criticism." However, a group practice requires adequate income to sustain all participants in the group-- leading right back into problems of intake. Where one engages in a "solo" practice one can still retain some form of self-examination. In fact, conducting both evaluation and "pure" research upon the materials generated in one's practice is an optimal way both to reinforce one's disciplinary identity and to keep treating one's act as something to be observed and dispassionately considered. Once again, our resolution is ad hoc: keep on examining your act and doing your very best to translate your ideals into practice.

Conclusions.

This all boils down to employing a sociological perspective with regard to one's own sociological practice. It's as simple as that. If we can avoid

taking the perspective of the businessman, counsellor or consulting engineer, but retain our disciplinary orientation as sociologists, as social scientists and not mere technicians, then we can avoid falling into these errors. All too often the "sociological perspective" has been taken as an excuse to think about it, talk about it, consider its possibilities and possible ramifications-- anything but get up out of our office chairs into the real world of daily life and do anything about it.

"Out there" is where the action is-- and, if we are to be practitioners rather than critics and commentators, our primary interest must always be action. I do not want to leave the reader with the impression that the sociologist ought not to be practicing because of these problems and pitfalls. Rather, we should engage in the wisest, most efficacious and sociologically-informed actions we can, despite all the reasons why it's impossible. Only thus can we make it possible.

I certainly have not resolved all these problems satisfactorily for myself. In fact, I have chosen to temporarily close down my private practice and regroup. While some five year in practice taught me a great deal and has led to important technical and theoretical developments[3], I have come to conclude that the commercial route is inadvisable, that "solo" practice-- by oneself in an isolated office-- is psychosocially intolerable, and that, after a certain point, one is best off to terminate an unsatisfactory arrangement and start over again afresh. That is not to say I do not believe a satisfying, successful and fulfilling private practice is impossible or undesireable. Rather, one had best learn from one's mistakes!

I am not sure how to go about entering the sort of private practice I feel would be desireable. Ideally-- speaking here of the sociological

counselor in clinical practice-- one would work in a multidisciplinary group setting generating intake by referral. Where this is not feasible, and for the sociological consultant, a group practice conducted by several sociologists would remain far more desireable than a "solo" practice.

Especially in the current political, economic and bureaucratic situation, it remains extremely difficult to establish a viable private practice as one's full-time occupation in a reasonably short time. Most successful private practioners of sociology developed their practices over a number of years while working in a more conventional academic or institutional setting. For those of us entering the profession in the late 1970's, however, it has become increasingly difficult to gain such a foothold; we are constrained to struggle and do it the hard way.

That is what we must do and so we should not shrink from the task. I still feel the freedoms of private practice outweigh its disadvantages and compensate for the difficulties in establishment. We, the current cohort of journeyman sociologists, must take the risk and act - and by our actions discover and develop means to establish professional sociological roles enabling us to maintain both economic and ethical viability. I believe it can be done and, by our doing it, we will ease the way for future practioners and also establish the legitimacy of practice roles for sociologists. We can work out solutions to these dilemmas and get private practice by sociologists institutionalized in this society-- but we can only do so by working, not by sitting in our armchairs and thinking about practice.

Footnotes.

1. My thinking with regard to many of the concerns expressed in this paper is strongly allied with and influenced by informal communications with John Glass, Robert Beilin and Nathan Hurvitz and their formal presentations at the session on "Clinical Sociology" which I organized and chaired at the 1979 Annual Meetings of the Pacific Sociological Association at Anaheim, CA.

2. On Clinical Sociological practice see Schwartz (1978), Glassner and Freedman (1979), Straus (1979a, b, c, d), Powers (1979). For information about the Clinical Sociology Association, contact the author; the Section on Sociological Practice of the American Sociological Association publishes a roster of sociological practioners and is a valuable resource regarding all forms of professional sociology.

3. See Straus (1977, 1979c, d).

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